Attachment 18.
to Family Care Waiver Application Pre-Print

State Quality Strategy

State Quality Strategy

Department of Health and Family Services
Family Care
CMO Quality Monitoring and Oversight Plan

I. DHFS Quality Monitoring and Oversight Strategies for Family Care CMOs

Introduction: Attachment 18 is an overall quality strategy for Family Care CMOs. While provider qualifications are addressed in this attachment, this document represents an overall quality strategy and not just a list of provider qualifications.

A. Purpose

The purpose of this paper is to describe the quality monitoring and oversight strategies for the demonstration phase of Family Care implementation that will be implemented by Wisconsin's Department of Health and Family Services (the department). Its contents outline and briefly describe the components of what will become a system for monitoring each CMO to determine if it is meeting prepaid health plan (PHP) contract requirements in the area of quality assurance and quality improvement (QA/QI).

B. Background

The Family Care legislation enacted with the 1999-2001 Biennial Budget Bill makes significant changes in Wisconsin's long term care (LTC) services and supports delivery system. These changes are aimed at ensuring better access to LTC services for all citizens of Wisconsin and improving the quality of life of people who need long term support services. The Family Care legislation authorizes the department to offer the Family Care benefit, which is a flexible array of health and support services designed to meet individual consumer needs and promote high quality outcomes in creative and cost-effective ways.

The Family Care benefit, during the demonstration phase, will be available to three populations of individuals; persons with physical disabilities or developmental disabilities or persons who are considered frail elderly. Eligible individuals must meet functional eligibility criteria established by the department. The new benefit is funded by integrating public funding streams for institutional and home and community-based LTC services. It provides a public subsidy for LTC services to all Wisconsin citizens who have any level of need for LTC and who meet the financial criteria for the public subsidy.

Several strategies are being used to bring about the restructuring called for in the Family Care legislation. Among them are:

- fundamental system changes in funding,
- changes in the way LTC care management is done,
- amplifying the consumer's voice through local LTC councils,
- maximizing consumer choice of services,
- expanding the scope of services beyond current program restrictions, and
- moving responsibility and authority for making key decisions closer to the LTC consumer.

Obviously, these changes will also have a significant impact on how the department monitors quality and determines whether in fact the goal of Family Care—to ensure access to LTC services and improve the quality of life of people who need LTC services and supports—has been achieved.

There are two key components in the Family Care model. First are the local Aging and Disability Resource Centers, where all Wisconsin citizens can easily get information and assistance on the full range of LTC services, supports and community resources available to people who need LTC. Here, early intervention and prevention strategies plus systematic preadmission counseling and LTC options counseling will help LTC consumers remain as independent as possible, and conserve their private resources, preventing or delaying the need to rely on government funds. Resource Centers will also be responsible for determining functional eligibility and cost-sharing levels for persons seeking access to LTC services.

The second major component of Family Care is the Care Management Organization (CMO), which is the delivery system that will provide or arrange for the provision of services included in the Family Care benefit. CMOs will be locally operated and will be designed to help people find, organize and pay for the LTC services and supports they need. The department will enter into a contract with a local CMO, and for each person enrolled, the CMO will receive a fixed amount of funding monthly, based on the person's level of functional disability. Under this arrangement, the CMO—as opposed to individual providers—is the entity that is accountable for monitoring, evaluating, and taking action as necessary to improve the quality of the services and supports delivered or arranged for under its contract with the department.

Each CMO, in partnership with the consumer who voluntarily chooses to join the CMO, will design and manage services and supports tailored to the consumer's needs and preferences in the most cost-effective manner. The major processes the CMO will use to facilitate care delivery are assessment, care planning, and coordination of all services needed by the consumer. The CMO may, in some cases, provide the needed services and in others it may arrange for service provision through subcontracted providers. Family Care also has a consumer-directed support option, which will give consumers or their families' control over funds that will be used to choose the purpose, type and means of support to meet LTC service needs. In such cases, the CMO's role is to make fiscal intermediaries and employment services available so that the consumer is able to maintain functional control of the budgeted funds.

The department, as part of the contracting arrangement, will provide the CMO a fixed amount of funding each month on a prepaid basis for each person enrolled. The prepaid amount is related to the projected need for LTC services based on the person's level of functional disability. The CMO assumes the responsibility of providing needed services in the Family Care benefit within the dollars provided. This is called risk-based contracting and is a strategy that promotes flexibility in how supports and services are managed while containing costs. It also offers an opportunity to increase the effectiveness of the department's health care quality improvement systems and test local innovations for quality improvement in a risk-based contracting environment.

C. Scope

What follows is a summary of the department's approach to monitoring quality in CMOs and a description of the quality oversight tools it will use to determine the effectiveness of the new Family Care model[1]. It does not describe the quality system for monitoring Aging and Disability Resource Centers.

[1] See **Attachment A** for a brief overview of each monitoring activity.

II. Quality in Family Care Defined

The department, under the Family Care model, pools funds from diverse sources—LTC institutions, home and community based services under Wisconsin's four 1915 (c) waivers, other state LTC funds, and some Medicaid state plan services currently under the fee-for-service program (FFS)—and manages those funds under a risk-based managed care contracting arrangement. In this type of arrangement, the department will contract with local organizations—CMOs—which will take on full responsibility for all benefit management, either directly or by utilizing a network of providers. In essence, when this approach is taken, the primary purchaser (the state) removes itself from directly managing payments and utilization of services and opens the door to buying high quality care and services from the contracting entity (the CMO). Under this model, the CMO can be held accountable in a way that has not been possible under FFS Medicaid.

A. Quality from the Consumer Perspective

The changed LTC system under Family Care will be monitored and assessed on a regular basis to evaluate the quality of services and supports provided by the entity called the CMO. As with all quality monitoring systems, quality must first be defined, and any definition should begin with what the system being monitored was created to achieve. As stated earlier in this paper, the central defining aim of Family Care is to assure better access to LTC services for all citizens of Wisconsin and improve the quality of life of people who need long term support services. While quality of life is a matter of subjective experience that does not mean it cannot be measured objectively. The consumers' view of quality can and will be sought out as an important element of the objective assessment of quality in Family Care.

In the early days of developing the Family Care model, a diverse 35-member group of stakeholders gathered to focus on defining quality in the redesigned system of LTC services and supports. This workgroup agreed that the primary focus for quality assurance and quality improvement in LTC redesign should be the achievement of desired consumer outcomes. Consequently, the group developed 14 outcomes[2] that are centered on the individual in need of LTC services, rather than on program, clinical, or even functional outcomes. The message the department heard from this workgroup is that LTC consumers want care and services that contribute to or at a minimum do not interfere with their quality of life including such issues as productivity and social life.

To assist in further defining quality in Family Care, the 14 consumer outcomes were used to define performance standards and measures for the redesigned LTC system. The performance standards recommended by the workgroup were used in the development of the quality standards that are used in the PHP contract the department will have with CMOs. The performance measures that were developed by the workgroup—many of which are included in Attachment C—will be used to count events related to particular outcomes, use them as yardsticks to measure progress, and show the CMO and the department where changes may be necessary.

[2] See **Attachment B** for the list of Family Care outcomes.

B. Other Perspectives on Quality

Beyond achieving consumer outcomes, LTC services and supports must meet health-oriented quality standards that are important to purchasers, care managers, providers and consumers as well. These standards encompass technical quality issues and typically focus on physical functioning, pain and discomfort, training programs, treatments, and safety, and aim to improve the health or functional status of the individual. As specialized expertise usually plays a greater role in setting standards and measures for health and safety outcomes, consumers have less of a role in setting expectations and judging whether or not standards have been met. This perspective is important and CMOs will also be expected to satisfy the requirements of quality standards and measures related to outcomes in this arena.

The department has sought input, on an ongoing basis, from relevant department staff, care managers and providers as it has developed its health and safety standards for Family Care. The department believes that improved health and safety outcomes are achieved by paying attention to structure and process standards that ideally are associated with results. However, in the absence of a clear relationship between structure or process and health and safety outcomes, there should at least be a consensus as to the importance of a given standard (i.e., a structure or process) in contributing to minimal or improved quality.

The Family Care statutes, the Family Care emergency rules, and the Home and Community Supports Contract are the principal repositories for the structure and process quality standards in Family Care. Examples of these standards include: CMOs must demonstrate the adequacy of their network, make arrangements for 24 hour service availability, implement monitoring systems to evaluate the quality of services provided by subcontracted providers, implement member complaint procedures, assessment and case management, and internal quality improvement programs. It is the department's intent to use these standards flexibly in the service of promoting improved consumer outcomes.

C. Next Steps

The first step in developing a quality monitoring and oversight system is to define quality in LTC. The department has taken this difficult step by involving important stakeholders in developing outcomes and standards that can be measured over time. The Family Care statute, emergency rule and CMO contract incorporates the perspectives of the consumer, the purchaser, the care manager and the provider into standards for access to care and other aspects of care and services related to improving quality. The next big step is to develop monitoring tools, techniques and strategies for regular and periodic reviews and evaluation of CMO of quality outcomes, and timeliness of, and access to, services covered under the Family Care benefit. This paper attempts to describe the monitoring system that will do just that.

In addition to monitoring procedures and reviews, the department must also determine the technical assistance and educational needs of the system components. Both the department and the CMO will need to develop new areas of expertise in order to implement a quality oversight system for Family Care in accordance with the goals and performance standards the department expects. As a result, the department needs to identify topics or areas for technical assistance that will strengthen the capabilities of Family Care CMOs and encourage the implementation of effective quality assurance and quality improvement systems. The monitoring activities

described here, especially the up-front, precertification reviews of CMOs described in the prospective assurances of quality section, will provide opportunities to identify technical assistance topics that need follow-up.

III. Family Care Quality Monitoring Plan

The department's approach to monitoring quality in Family Care focuses on two important levels of quality in a CMO: the CMO's commitment to improving its LTC delivery system overall, and its performance in achieving outcomes for individual members. *System level* monitoring activities include prospective assurances of quality, annual site reviews, and CMO performance reports. Monitoring activities on the *individual member level* include CMO member, family, and guardian interviews and surveys, and individual service plan reviews. In addition to the monitoring activities performed by the department, the department will arrange for an independent assessment of the impact of Family Care on member access to care and the quality of that care.

The Office of Strategic Finance's Center for Delivery Systems Development (the center) is responsible for coordinating and facilitating the implementation of Family Care and the quality monitoring and oversight plan. In order for the department's quality approach to be successful, center staff must build on and coordinate activities with divisions and units within the department that are currently involved in quality assurance and improvement in LTC. For example, the center and Division of Supportive Living's Bureau of Developmental Disabilities Services should explore how to coordinate their review activities, ideally so that one review or component of a review could satisfy some components of a Family Care review to avoid duplicate monitoring. This work will not always be easy or quickly accomplished. Because of the complexity of the issues, coordination of review activities, role clarification and resources are being addressed elsewhere and will be considered during the implementation phase of the department's monitoring and oversight plan.

A. CMO System Level Reviews

1. Prospective Assurances of Quality

Potential CMOs must seek certification to provide Family Care services. The department will certify CMOs by evaluating each potential contractor using a set of structure and process standards. Certification standards are derived from a number of sources. First, the Family Care legislation and administrative rules contain a set of standards that pertain to a CMO's provider network. Second, the Health and Community Supports contract the department will enter into with each CMO contains a number of organizational standards and expectations. In addition to state standards for CMOs, federal regulations require that states that use federal Medicaid dollars in a risk-based contracting arrangement assure that contractors have the capacity to meet federal Medicaid managed care regulations.

(a) Certification Standards required by the Family Care Statute

Certification to be a CMO requires each entity to demonstrate that it has adequate availability of providers to meet the preferences and needs of potential enrolled members. To meet the requirements of the Family Care statute, the CMO applicant must submit documentation of its

capacity to assure timely provision of Family Care services to the expected enrollment in the CMO's service area. As part of the documentation, the CMO must show that it is not merely creating a situation where members are steered to existing residential slots, but are instead treated as individuals whose preferences are honored. Such documentation may be in the form of written agreements with providers who are available to provide all LTC services in the Family Care benefit in sufficient quantity to meet the needs of the potential enrolled membership or a description of how the CMO plans to provide the service directly to the expected enrollment.

The department will review each CMO's documentation and conduct any necessary reviews to determine if the CMO has adequate capacity to serve the expected enrollment. In the future, local LTC councils, which will have 51% consumer representation, will also review relevant documents and make recommendations to the department on whether or not the applicant meets certification requirements.

(b) Health and Community Supports Contract Certification Standards

The second component of the precertification review is compliance with a number of organizational standards that are established under the CMO contract. These standards cover such dimensions as financial stability, member rights, complaints and grievance specifications, member safety and risk plans, advance authorization and utilization management systems standards, provider selection and retention policies, QA/QI program and workplan, member information and marketing materials. As part of the pre-contract review, each potential CMO must submit organizational documents that show that it has the capacity to meet contract requirements. Department staff with specific technical knowledge will review all relevant CMO documentation. The department may also conduct on-site reviews as necessary prior to entering into a contract with a CMO.

As with the provider network adequacy standards, each potential CMO's documentation will be reviewed for consistency with the guiding principles of Family Care, as well as for evidence of adequate capacity to meet state and federal managed care contract requirements. Follow up communication from the department will indicate the results of the review. Results may show that the CMO's documentation was acceptable or that additional documentation is needed prior to contract signing. In some cases, a CMO may be required to participate in technical assistance sessions or attend mandatory training in specified areas. Additionally, a CMO may be required to meet performance expectations during the contract period that are attached to the contract in the form of an amendment. In such cases, the department will conduct reviews and site visits as necessary to validate progress made in those areas.

2. Annual Site Reviews

In addition to site visits conducted during the contract period on an as needed basis to address issues identified through the precertification review and the start-up phase, the department will conduct annual reviews of all CMOs in the three areas described below. These reviews will generally occur on site and be conducted by review teams composed of department staff, a relevant LTC provider, a registered nurse, a social worker and a consumer if possible. If it is not possible to secure consumer participation for all site visits, consumer input on relevant materials will be obtained off site. Consumers who participate in this process will be compensated.

Annual site reviews will emphasize CMO system level issues including such issues as system-wide quality improvement, access, choice, quality of life of members, safety and the system in place to ensure safety and, most importantly, the degree to which Family Care outcomes are being achieved. It is expected that these reviews will also incorporate findings of other monitoring and oversight activities discussed in this paper into the annual review process.

(a) CMO QA/QI Program Implementation

In Family Care, the CMO becomes the organization that is responsible for delivering a set of services and supports for a defined population of individuals. The state, in turn, has an obligation to monitor and assess how the CMO performs as a whole and how it plans to continually improve its performance. The CMO's internal quality assessment and quality improvement (QA/QI) program is the mechanism it will use to monitor and evaluate care delivered to its members and take actions as necessary to improve care rendered by all CMO providers, as needed. How the CMO implements its internal QA/QI program is of foremost importance to the department.

Under risk-based contracting, the contractor is required by federal law to operate a program of quality assessment and improvement (QA/QI). QA/QI are CMO administrative functions that drive the organization on to continual improvement. These functions involve a number of interrelated activities, such as monitoring basic health and safety, performance measurement and improvement using objective quality indicators, developing standards of care and monitoring providers against established standards, and implementing methods to strengthen consumer involvement in CMO quality activities. The CMO will be expected to provide documentation that it has or is actively implementing an internal QA/QI program that meets contract standards and that the CMO has a plan for incorporating the experience of CMO members into the evaluation of the QA/QI program.

As part of its quality monitoring and oversight activities, the state will review, at least annually, how well the CMO is implementing key quality assurance and quality improvement functions CMO-wide, and the impact and effectiveness of the CMO QA/QI program. This monitoring will be done on-site and will entail interviewing key staff, providers and consumers and reviewing relevant documentation. The review will focus primarily on the assurances made by the CMO during the precertification review on the QA/QI plan, access standards and other contractually required standards to assess the CMO's progress on implementation. Also, the department will review the CMO's own evaluation of its internal QA/QI program. For example, reviewers will assess whether or not the CMO is completing the activities on its QA/QI workplan on a timely basis and whether or not the CMO's self-evaluation includes recommendations for needed changes.

(b) CMO Provider Network Monitoring

In addition to the precertification review, on an annual basis, the department will conduct an on-site review to evaluate the geographic distribution of available service providers and whether the CMO is meeting standards for timeliness of services. As part of this review, the department will ensure that each CMO's network is structured in a way that considers the geographic location of providers and enrollees, including such factors as distance, travel time, and the means of

transportation normally used by enrollees. If the CMO contracts with providers outside its service area, the CMO will have to justify these arrangements as either making it easier for some enrollees to reach the particular provider or other reasons such as inability to contract with a sufficient number of providers within the service area. The review will also include an assessment of CMO policies and procedures, documented processes, provider files on-site at the CMO's administrative offices and CMO staff interviews will be conducted.

(c) Monitoring CMO Provider Selection

CMOs are required to have a local process to assure that persons providing services and/or supports are trained and qualified to perform their duties. In part, this will consist of verifying that any subcontracted provider meets pre-set CMO specific standards that have been prior approved by the department. Additionally, CMOs must evaluate the performance of each subcontracted provider on a periodic basis, using member input on the quality of providers, complaints and grievance reports, performance measures and other information. They also must report to the department whenever a subcontract is terminated because of quality problems with a provider.

During the annual on-site review, department staff will interview CMO staff and providers and review CMO documentation to determine if the CMO is adhering to its policies and procedures in this area. The department may also conduct a survey of CMO subcontracted providers in order to assess CMO performance from the provider's perspective.

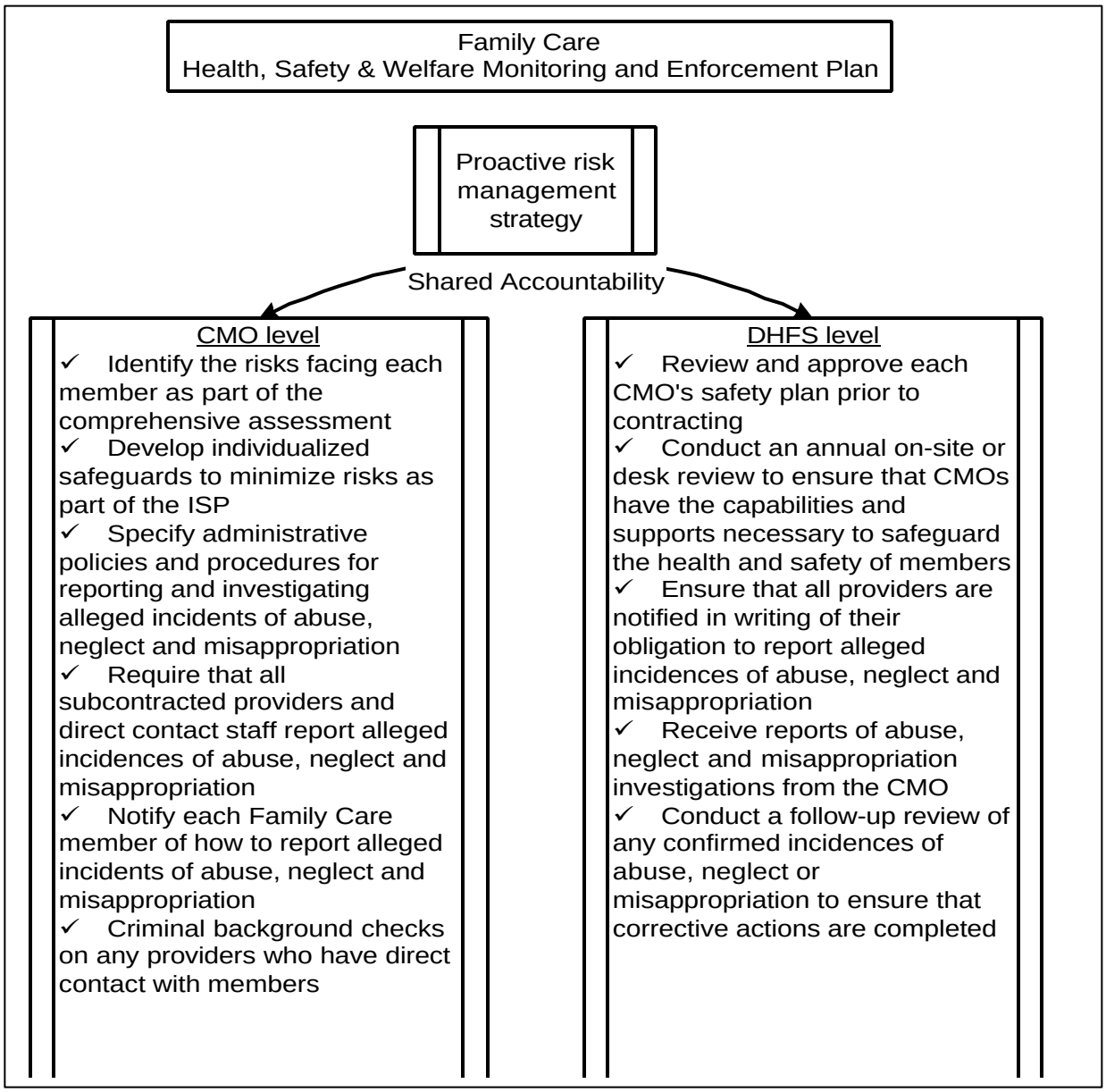
(d) Health, Safety and Welfare Reviews

In Family Care, CMOs and the department share accountability for assuring the health, safety and welfare of CMO members (see diagram below). On the CMO member level, each CMO must identify the risks facing each member as part of the comprehensive assessment and develop individualized safeguards to minimize risks as part of each member's service plan. On the CMO system level, each CMO must have administrative policies and procedures for reporting and investigating alleged incidents of abuse, neglect and misappropriation of member's property prior to contract initiation. The CMO must also assure that all subcontracted providers and direct contact staff report alleged incidences of abuse, neglect and misappropriation. In particular, the department will review whether or not the CMO has implemented a notification process so that each Family Care member (and/or significant family members/guardians) understands how to report alleged incidents of abuse, neglect and misappropriation and a mechanism to do criminal background checks on providers who have direct contact with members.

On the state level, the department is responsible for monitoring and assuring that appropriate health and welfare safeguards are in place and effectively implemented by the CMO. Prior to contracting, the department reviews and approves each CMO's safety plan. Annually, the site-visit team will review relevant documentation to ensure that CMOs have the capabilities and supports necessary to safeguard the health and safety of members. Specifically, the team will check to ensure that providers are notified in writing of their obligation to report alleged incidences of abuse, neglect and misappropriation and review CMO reports of abuse, neglect and misappropriation investigations. A follow up review of any confirmed incidences of abuse, neglect or misappropriation will occur to ensure that required corrective actions are completed.

Not every situation of abuse, neglect or misappropriation can be prevented with processes or procedures however. The department will also expect CMOs to look beyond policies and procedures that prohibit abuse, neglect, and misappropriation, to avoid circumstances that contribute to the vulnerability of its members. One way this is accomplished is by increasing choices for member living arrangements and assistance wherever possible, and by promoting community visibility and community connections. When members find themselves in conflicts that increase their vulnerability, ideally, CMO staff and providers will have the problem solving processes and negotiation skills necessary to be of assistance. During annual health, safety and welfare reviews, the department will look at whether CMO policies and practices proactively direct attention to the circumstances in which members are vulnerable as well as are effective in dealing with abuse and neglect when it occurs.

If the department finds that a CMO is not adequately meeting the health, safety and welfare needs of its members, the CMO contract specifies that a variety of corrective actions may be imposed. These range from corrective action plans to withholding payment and include contract cancellation in extreme circumstances. Under certain circumstances, when a pattern of abuse and neglect is suspected, a review of relevant documentation from a representative sample of CMO members may be conducted to determine that health and safety concerns and issues are being addressed in CMO members' service plans and CMO-wide.



3. CMO Performance Reports

On an annual basis, the department will assess the impact and effectiveness of each CMO's quality assessment and performance improvement strategy on two of the basic elements of its program; performance measures and performance improvement projects. The review will entail an assessment of the CMO's self-reported performance on seven contractually required performance measures that are tied to the Family Care outcomes[3]. The CMO will also report the results of any outcome-focused performance improvement projects it has conducted during the contract year.

[3] See **Attachment C** for the complete list of CMO performance measures. The performance measures that are followed by an asterisk are the contractually required measures.

(a) CMO Performance Measures

On a regular basis, CMOs are required to submit member-level data on seven contractually required performance measures (see footnote) and achieve any minimum performance levels that are established by the department. Each performance measure is associated with one of the Family Care outcomes and for the most part uses data collected on the Human Services Reporting System (HSRS). Developing a CMO performance measure set that meets the department's expectations is a multi-year process and will be phased in over a several year period.

In addition to self-reported CMO data, the department will monitor CMO performance based on data it obtains through the MMIS system on Medicaid state plan services provided/billed by Medicaid FFS providers, such as hospitalizations (see footnote). Holding CMOs accountable for performance in these areas however, may be restricted because outcomes may be substantially affected by factors outside the CMO's control.

The department will analyze each CMO's self-reported performance data on a periodic basis focusing on outcomes of care and services delivered to CMO members. As part of this analysis, processes will be developed for verifying the accuracy and completeness of CMO data. To the extent feasible, statistical methods will be used to compare CMOs with each other and to existing programs. When outliers are detected further analysis will be done to determine if the outlier is a best practice or indicates an opportunity for improvement.

Cooperatively, in conjunction with input from CMOs, minimum performance levels on each measure will be established once baseline data is obtained. Data collected during the first contract period will provide a point of reference for more detailed performance tracking. If the data is reliable, it will be used as a yardstick that will provide the department and individual CMOs with benchmarks against which performance levels can be set and future performance can be measured. An example of a performance level is: Eighty-five percent of CMO members live in a setting of their choice. The department will consider historical CMO and other Medicaid FFS and 1915 (c) waiver performance data and trends when establishing performance levels for CMOs. Once a baseline is established, a minimum performance level will be set prospectively upon contract initiation and renewal so that the CMO will have sufficient time to meet or exceed the performance level.

(b) Performance Improvement Project Reports

During the first contract year, each CMO will initiate at least one performance improvement project. Each CMO selects its own project topic, but the project must focus on at least one Family Care consumer outcome that is a relevant area of concern for the CMO. The topics of particular CMO quality improvement efforts should emphasize issues that consumers identify as needing attention or which reflect deficits found through monitoring activities. Over time, a project will involve measuring performance, implementing system interventions, evaluating the effectiveness of the interventions, and planning for sustained or increased improvement. The department will focus its review of CMO improvement projects on whether or not the CMO achieved a level of performance that exceeded its own baseline performance or measures a percent improvement in outcomes for the quality indicators used in the project.

B. CMO Member Level Reviews

1. Overview

Two types of reviews are described in this section. First, member outcome reviews, which will look at whether or not CMOs help consumers achieve desired outcomes. The member outcome reviews will involve interviewing members, case managers and other providers, family members and guardians. Reviewers will conduct home visits and meet with guardians to collect feedback from anyone involved in the member's care. The processes and tools that will be used to conduct member outcome reviews are described in the Monitoring Family Care Outcomes section below.

The second review described in this section—service plan reviews—looks at the CMO's capacity for supporting members to meet their service needs while respecting their individual preferences and desired outcomes. A review consists of targeting a subgroup of CMO members, such as any member who relocates from an institution into the community, and reviewing available information about services, supports, time frames, staff responsible for service provision, and documentation of the member's preferences and needs in the service plan. The purpose of the review is to determine how well the CMO is using the assessment and planning process to coordinate supports for the individual and whether or not the CMO is writing service plan goals that reflect the individual's stated desires and preferences.

2. Monitoring Family Care Outcomes

The Family Care proposal emphasizes the achievement of consumer outcomes as an important element of quality. Accordingly, the value of the CMO to members is demonstrated when CMO services and supports facilitate outcomes that are important to the person served. CMO employees and providers learn about members' priority outcomes during the CMO comprehensive assessment and during day-by-day interaction with members. Members' individual service plans (ISP) describe methods the CMO uses to organize resources and coordinate services and supports that facilitate the achievement of outcomes which members seek. Once the CMO has aligned services and supports to facilitate member outcomes, it's important to evaluate if members are achieving desired outcomes. This section proposes, as part of the framework for monitoring quality in Family Care, a strategy for measuring the effectiveness of the CMO in relation to its capacity to respond to the individual needs and desired outcomes of its members.

(a) Member Outcome Reviews

Monitoring and measuring CMO performance relative to the Family Care consumer outcomes require a different approach than for operational and financial performance. Basically, effective mechanisms should combine objective tools or guidelines and strategies for listening and learning from members to make valid and reliable decisions about the presence or absence of outcomes. In addition, tools and strategies may necessarily be different for different member subgroups because of the wide variation in member expectations, perceptions, and capacities.

The department's primary monitoring approach for determining whether Family Care consumer outcomes are present or absent will be by gathering information directly from CMO members in

the form of member survey/interviews, site visits to wherever members spend their time, and through direct observation of service delivery and service settings. Department reviews will take the form of one-on-one interviews or small focus groups to capture the perceptions of members and their significant others on social and support networks, lifestyles and role functions, activity patterns, quality of life, expressed satisfaction and other factors related to outcomes. Concurrently, CMOs are also expected to validate, during their own routine care plan reviews and other interactions with members and their significant others, whether or not member-referenced outcomes are being achieved.

(b) Member Outcomes Measuring Process[4]

Gaining the information necessary to measure the presence or absence of outcomes will be a challenge. Most information will be gathered during one-on-one meetings with a representative sample of CMO members and others who know the member best. The department will identify the sample from enrollment data based on objective criteria, such as number of months enrolled. Sample individuals' informed consent will be obtained prior to their participation in the interview. The department may assign these information-gathering meetings to a unit within the department or to non-state agency under contract with the department, or both. The actual content and sequencing of activities that occur during the information gathering phase of the review will be outlined in a department-issued guide.

Reviewers will be trained to perform this type of flexible, one-on-one interview and will have skills in overcoming difficulties with communication. Review staff will visit each individual included in the sample in their homes or places of employment or service. They will discuss the status of the person with the person, their guardian and key family members and with service providers involved in providing services to the person.

The measuring phase of the review process will entail making decisions based on department-issued guidelines in order to judge the presence or absence of a particular Family Care outcome for an individual A database will be developed and data from the member and significant other interviews/surveys will be entered and analyzed for each CMO and aggregated across CMOs.

Data compiled will detail the characteristics and demographics of those interviewed and allow the department to make inferences about the presence or absence of Family Care outcomes within a CMO and across the Family Care delivery system as a whole. Data gathered from this approach will be used for a variety of purposes, including implementing technical assistance and improvement projects, encouraging CMOs to implement interventions that have a significant positive effect on member outcomes, and reevaluating the Family Care delivery system structure overall.

3. Reviewing CMO Member Service Plans

This section describes how service plan reviews will be conducted. A review of this type primarily consists reviewing available information about services, supports, time frames, staff responsible for service provision, and documentation of the member's preferences and needs.

[4] The process described here closely follows the processes used *by The Council on Quality and Leadership in Supports for People with Disabilities'* **Personal Outcomes Measures** procedures manual, ©1997.

The purpose of the review is to determine how well the CMO is using the assessment and planning process to coordinate supports for the individual and whether or not the CMO is writing service plan goals that reflect the individual's stated desires and preferences.

(a) Service Plan Review Process[5]

Under Family Care, the guidance of the waiver programs and Medicaid managed care programs will be sought as a comprehensive service plan review process is developed. As previously mentioned, service plan reviews look at the CMO's capacity for supporting members and meeting their service needs while respecting individual preferences and desired outcomes. As such, these reviews are seen as a method to assess the quality of services and supports in CMOs and will be most effective if they are integrated with other ongoing quality management efforts described in this document and should never become part of a punitive process. The department intends to emphasize continuous improvement of CMO processes throughout its monitoring activities. In general, service plan reviews should be seen as a way to support CMO activities that aim to identify opportunities for improvement in the delivery of care and services to CMO members.

During the first year of Family Care implementation, we are proposing a strategy of targeting fewer but higher risk plans for review instead of continuing with prior approval of all service plans. Reviews will be conducted on an ongoing basis[6] and will be carried out concurrently as the CMO develops and implements the member's service plan. Two distinct groups of CMO members' service plans will be reviewed. The first group will be a randomly selected five percent sample of new and continuing CMO members. The second group will consist of targeted cases where the functional eligibility screen or some other tool will be used to identify members that may be at a higher risk for health, safety and welfare issues. In addition, the timing of the review will change in that it will occur at the same time the CMO is implementing the member's service plan instead of prior to service plan implementation.

The reasons for targeting reviews will be similar to those used in the current 1915 (c) waivers. Examples of target review criteria include: health and safety risks, guardian or care manager request for assistance, follow up to a prior critical incident where abuse, neglect or some other significant event compromised health, safety or welfare, BQA reports of violations in the facility the person resides, or even just a routine follow up from an earlier targeted review to make sure the problem situation has not recurred. In addition to these examples, a targeted review will occur whenever a person is moving from an institution or is experiencing some other major change in life status, as it is believed that risks associated with community services are higher in these situations.

[5] Issue paper 077, *Implementing service plan reviews in Family Care*, looks at implementation issues around service plan reviews in greater depth.

[6] It is anticipated that for each CMO a sample will be selected on a monthly basis, of new and continuing members. Sampling will be done based on criteria and reviews will be conducted as data are collected for the review.

(b) Service Plan Review Tools

The primary goals[7] of service plan reviews in Family Care are to ensure that individual CMO members are provided information and support which can assist them in selecting services and providers that address their needs and help them realize the outcomes they want to achieve. Guideline driven protocols will need to be developed in order to determine if CMO assessment, service planning, and implementation processes contribute to the achievement of desired outcomes. The service plan review process will entail reviewing CMO documentation and may in some cases include a face-to-face interview with the member and/or guardian.

Service plan review protocols will be developed that will instruct personnel performing reviews. These protocols will specify the areas to be covered by the review, the sources of data for the review, procedures to be followed to promote accuracy, validity and reliability of the review, and tools (i.e., forms, etc) necessary to implement each protocol. New Family Care protocols will draw from existing review protocols (that are used for 1915 (c) CIP/COP waiver programs and Medicaid managed care programs). In some cases, new tools will need to be developed to address areas not currently addressed. When this situation occurs, protocols will be created by a defined group of department staff and stakeholders who have appropriate expertise, skills, experience and interest.

Since good member outcomes are the ultimate goal of Family Care, to the extent feasible, service plan reviews will also include an assessment of whether member-defined outcomes have been achieved. Relating outcomes to CMO performance happens over time. That is, outcomes emerge after a step is taken or a specific procedure is carried out. In some cases this is immediate but in most, outcomes occur at the time an episode of care is completed or more often over a longer period of time. Since some new member service plan reviews may occur before the service plan is fully implemented, measuring outcomes accurately may prove difficult. Targeted reviews of service plans of continuing CMO members can better be used to provide information about member outcomes and the relationship of CMO processes to the achievement of outcomes.

(c) Service Plan Review Implementation

The department's Quality Oversight Committee will direct the implementation of service plan reviews. Reviewers, either state staff of a contracted organization, will conduct service plan reviews according to specifications that are determined by the Quality Oversight Committee. Service plan reviews will occur with advanced knowledge of the review criteria in order to encourage CMOs to improve services and supports in those areas prior to the review, thus improving care sooner rather than later.

Each service plan review will result in written case-specific findings and recommendations by the review team. Case specific reports will specify whether or not care and services provided by the CMO meets standards and whether any follow up is required. If a reviewer finds that service plans do not agree with the stated disabilities and needs of a member in critical areas, or if basic member needs are overlooked in the comprehensive assessment, an immediate referral will be made to the department before any action is taken. The Quality Oversight Committee will

[7] **Attachment D** shows an overview of content of the targeted review in Family Care.

examine the findings of immediate referral cases in a timely manner and, if the Committee agrees with the reviewer's findings, the CMO will be informed of the review results and recommendations. If after further investigation it is determined that the effect on the member is serious, the CMO will be directed to take immediate corrective action to ensure that the essential needs of the member are adequately addressed.

In addition to case-specific reports, the review team will produce a trend report specific to each CMO that includes a summary of its findings and recommendations for problem resolution, quality improvement, and follow-up activities such as technical assistance. Summary reports will be submitted to the department's Quality Oversight Committee at the end of each quarter and will be assessed and commented upon by the committee before they are finalized. The Quality Oversight Committee may then direct the review team to have the findings reviewed by the CMO in order to assist in their interpretation and the development of follow up plans for problem resolution and quality improvement.

C. Independent Assessment

In addition to the monitoring and oversight activities described above, the department will arrange for an independent evaluation of Family Care which will include the following components: a measure of the availability of services under Family Care compared to the level of services that existed prior to Family Care, an evaluation of the impact of Family Care on the quality of services provided to CMO members, and the cost effectiveness of Family Care. The independent evaluation will be carried out under a contract between the department and independent assessor, The Lewin Group, an organization that is external to and independent of the department.

The intent of the evaluation is to confirm and supplement programmatic information provided by the department and not to duplicate the department's efforts to assess Family Care. The independent assessor will begin its review by analyzing existing documents, such as complaint and grievance logs and any other quality/access reports produced by the state and by meeting with key stakeholders. A comprehensive programmatic research design will be used to describe and evaluate care and services delivered to Family Care participants. The department will use the independent assessor's results and recommendations as a tool to improve Family Care.

The independent assessor's final written report will draw conclusions as to the quality of care and services furnished by individual CMOs, and will detail strengths and weaknesses and recommendations for improvements. In addition, when appropriate, comparative data about all CMOs may be reported. The department will provide the results of the independent assessment to state and local LTC councils as well as the department's Quality Oversight Committee and all interested parties including members of the general public who request them.

Attachment A

Overview of DHFS Quality Monitoring and Oversight Activities for Family Care CMOs

Activity	Purpose	Conducted By	Frequency & Methodology	Review Criteria
CMO System Level Reviews				
CMO Certification	Assure: ▪ CMO capacity to serve potential Family Care participants ▪ CMO meets contract standards	▪ CDSD staff ▪ Department input	▪ Prior to initial contract signing ▪ Prior to renewing contract ▪ On-site and desk review of CMO documentation	Contained in: ▪ Family Care statute and rule ▪ CMO contract ▪ CMO Certification manual
Annual Site Reviews	Assess: ▪ CMO QA/QI Program Implementation ▪ CMO Provider Network Adequacy ▪ CMO Proactive Risk Management Strategy	Review team consisting of: ▪ DHFS staff ▪ LTC provider ▪ Registered nurse ▪ LTC consumer	▪ Once during contract period ▪ On-site review ▪ Combined review of documentation and interviews of appropriate parties	Contained in: ▪ Family Care statute and rule ▪ Federal regulation ▪ CMO contract ▪ CMO Annual Site Review manual
CMO Performance Reporting	Assess: ▪ CMO self-reported performance on CMO contract measures ▪ CMO system improvements in Family Care outcomes	▪ CDSD staff ▪ Other DHFS staff ▪ DHCF operations staff & decision support contractors ▪ DSL HSRS staff	▪ Annual review ▪ Monthly data submissions on HSRS ▪ MMIS data ▪ Data from complaints and grievances and other sources	Contained in: ▪ Family Care statute and rule ▪ Federal rule ▪ CMO contract ▪ CMO technical assistance documents
CMO Member Level Reviews				
Family Care Outcomes Monitoring	Measure: ▪ CMO performance relative to the Family Care consumer outcomes	▪ DHFS staff and/or DHFS contracted staff	▪ Annually ▪ One-on-one meetings with a sample of CMO members and significant others	Contained in: ▪ Family Care proposal ▪ Family Care statute and rule ▪ CMO contract ▪ Outcomes monitoring manual
CMO Service Plan Review	Assure: ▪ CMO members' needs are met ▪ Assessment and service plan timelines are met ▪ Family Care services are timely ▪ Coordination of services ▪ Member outcomes are achieved	▪ A review team that may include: – BDDS staff – BALTCR staff – TMG – Other	▪ Ongoing targeted reviews of new and continuing CMO members ▪ Targeted case reviews ▪ 5% random sample ▪ Reviews are concurrent with ISP implementation	Contained in: ▪ Family Care rule ▪ CMO contract ▪ Service plan review procedure manual
Independent Assessment				
Independent Assessment	Assess: ▪ Quality outcomes ▪ Timeliness of services ▪ Access to services ▪ Cost-effectiveness	▪ The Lewin Group	▪ Ongoing, 3 year timeframe ▪ Member surveys ▪ On-site audits ▪ Sampling ▪ Individual case reviews	Contained in: ▪ Federal waiver requirement ▪ State statutes and regulations ▪ Request for Proposal ▪ Independent Assessment Contract

Attachment B

Family Care Consumer Outcomes

1. People are treated fairly.
2. People have privacy.
3. People are respected and have dignity.
4. People choose their services.
5. People choose their daily routine.
6. People achieve their employment objectives.
7. People choose where and with whom they live.
8. People participate in the life of the community.
9. People remain connected to informal support networks.
10. People are free from abuse and neglect.
11. People have the best possible health.
12. People are safe.
13. People experience continuity and security.
14. People are satisfied with their services.

Attachment C

CMO Performance Measures

CMO Performance Measures (Group 1 – Self-determination and Choice)

1. % of members who report being treated fairly.
2. % of members who voluntarily disenroll because they are dissatisfied with the CMO.*
3. % of members who report that they feel free to voice concerns to their case manager.
4. % of members who have written advance directives (i.e., a living will or designated a durable power of attorney for health care).
5. % of members who report being satisfied with the amount of privacy they have.
6. % of personal care workers (PCW) added to CMO provider network to accommodate members' choice of PCW.
7. % of people reporting that they have access to the supports they need to maintain their independence.
8. % of members who say they know how to (or can) contact someone to help them exercise their rights
9. % of members who report they are listened to and get an appropriate response when they voice concerns.
10. % of members enrolled in or choosing some level of Self-Directed Supports. *
11. % of members who report that they are listened to and are treated as important.
12. % of members who report they are asked how they want to be addressed
13. % of members who report that their wishes and preferences regarding their care, services and support staff or providers are respected.
14. % of members who have used paid staff for help at home who report that they chose/hired the paid staff who help him/her at home (e.g., personal care worker, supportive care workers). *
15. % of members with no informal (unpaid) support use on their most recent functional and financial screen who were using at least one informal support on their previous functional and financial screen.
16. % of members who report that they choose how to spend their free time.
17. % of members who report that they have the support they need to access to the outdoors.
18. % of members who report they have access to common living areas.
19. % of people who report that they choose their times to wake up, have meals, go to bed, etc.
20. % of people whose current and principal employment setting is a sheltered workshop, a prevocational work site, or a supported employment setting. *
21. % of members who are doing volunteer work by sex and age ranges.
22. % of members who are satisfied with their employment or are making satisfactory progress toward their employment goals.
23. % of direct service providers who have consumers and/or family members on their boards or advisory committees.
24. % of members who report that the CMO is able to perform the service as outlined in the care plan (the interviewer should have the care plan along with when doing the interview).
25. % of members who report that they are able to use their environment to the best of their ability and according to their own choices.

CMO Performance Measures (Group 2 – Community Integration)

26. Transportation options available to members and utilization by type.
27. Living arrangements used by members (e.g., congregate by % of beds, nursing homes, adult family homes, private residences), and percent of membership in each setting. *****
28. % of members who are relocated into the community from an institutional setting. *****
29. % of members who report that they are living with whom they prefer to live.
30. % of members who report having adequate transportation.
31. % of family members with an adult family member who has LTC needs living in the home who report satisfaction with the support they receive from the CMO.
32. % of members who report that they are able to maintain relationships with their families and friends when they want to.
33. % of informal supports, who are the primary caregiver, who state that they are getting the help that they need (includes respite, home care, education, and emergency back-up services).
34. % of members who report that their contact with their informal support network is as they want it to be.

CMO Performance Measures (Group 3 – Health and Safety)

35. % of members who report that they can safely do what they want to do in their own home and in the community.
36. % of members who have had an injury caused by a fall.
37. % of members who have a person identified to act in his/her best interest if he/she becomes incapacitated.
38. % of members who report that the locations of certain specific health services and supports are convenient (e.g., day centers, congregate meals, transportation, etc).
39. % of members who have a regular doctor or a regular source of primary care.
40. % of members who report that providers/staff are friendly and courteous.
41. % of members who report that they are satisfied with the case management teams response to health and safety concerns.
42. % of care management team members (i.e., social service coordinator and RN) who separated during the reporting period.[8] *****
43. % of members who say that they know what medication side effects to watch for.
44. % of members who are taking 9 or more different medications on the most recent assessment. (This includes prescription and over the counter medications.)
45. % of members who have had a visit to a primary care physician in the last year.
46. % of members how report that they were offered an opportunity to receive an influenza vaccine in the last year.
47. Staff turnover rate for personal care workers.
48. % of members who report that the CMO responds promptly to their service needs.
49. % of members who are satisfied with their progress in terms of growth, change, and recovery.
50. % of members who have an ER visit for ambulatory care sensitive conditions.[9]

[8] Separation is defined as movement out of an organization (i.e., it includes resignations as well as terminations). Separations do not include transfers or promotions within an organization.

[9] Conditions for which hospitalizations can be largely prevented with consistent, available ambulatory care and adherence to treatment/self-care protocols: angina, asthma, bacterial pneumonia, cellulitis, chronic obstructive

CMO Performance Measures (Group 3 – Health and Safety)

51. % of members who have a hospital stay that may have been preventable.[10]
52. % of members with prolonged, unrelieved pain, depression, fatigue.
53. % of members with symptoms of depression on the most recent assessment. (Stratify by without and with antidepressant therapy.)
54. % of members who are cognitively impaired on their most recent assessment.
55. % of members who are determined to be incontinent on the most recent assessment (bowel or bladder) and were not on the previous assessment excluding members who were comatose, had indwelling catheters, or ostomies at the most recent assessment.
56. % of members with occasional or frequent bladder or bowel incontinence without a toileting plan.
57. % of members who have had a urinary tract infection on their most recent assessment.
58. % of members noted with a weight loss on the most recent assessment (5% or more in 30 days or 10% or more in the last 6 months) compared to their previous assessment.
59. % of members noted to have feeding tubes on their most recent assessment.
60. % of members who have been assessed as having dehydration on their most recent assessment.
61. % of members who are bedfast on their most recent assessment.
62. % of members who have had at least a one level decline in two or more ADL functions over two assessment periods.
63. % of members who have had at least two levels of decline in one or more ADL functions over two assessment periods.
64. % of members with visual impairment, hearing impairments or poor expression or understanding, who have had no corrective action taken.
65. % of members who have been assessed with any stage pressure ulcer(s) – stage 1-4 – on their most recent assessment.

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pulmonary disease (COPD), congestive heart failure, convulsions or seizures, dehydration, diabetes, failure to thrive, gastroenteritis, hypertension, hyoglycemia, immunization related conditions, iron deficiency anemia, kidney/urinary infection, nutritional deficiencies, severe ear, nose and throat infections, and tuberculosis.

[10]A hospital stay that may have been preventable is the term used to describe inpatient hospital admissions for the ambulatory care sensitive conditions described above.

Attachment D

Overview of Targeted Review of Service Plans in Family Care

Targeted Plan Review Types	Purpose in Family Care
1. Review of CMO comprehensive assessment	▪ verify that a comprehensive assessment was completed within 30 days of enrollment in a CMO ▪ verify that the comprehensive assessment identified at least those needs that were identified by the FFES
2. Review of service plans of new Family Care enrollees	▪ verify that an initial individualized service plan was completed within 60 days of enrollment in a CMO ▪ confirm that the member's ISP is sufficient to meet the member's needs as identified in the comprehensive assessment or if there are significant unassessed needs identified in the assessment that are not addressed in the ISP ▪ verify that the ISP identifies the "Family Care outcomes"[11] of value for the member ▪ verify that all resource allocation and case planning procedures were used in the development of the ISP so as to strike a reasonable balance between the desired "Family Care outcomes" identified by the member and care planning team and cost efficiency ▪ verify that the member was provided with the information about available services and providers needed to make informed choices ▪ verify to determine if potential resources for supports and services are considered from other sources such as family, friends, guardian, significant others, neighborhood and community, publicly funded supports and services available to all citizens ▪ confirm that services and support items identified in the ISP are in place within 60 days of enrollment in a CMO, or within 30 days of any revision to the ISP ▪ verify that the full range of support and service coordination options are available [12] ▪ verify that there are mechanisms to coordinate health related services and

[11] Note: "Family care outcomes" are positive consumer outcomes that include, but are not limited to: safety; best possible health; self-determination and choice in development of the individualized service plan, selection of caregivers, daily routine, living situation, etc.; privacy; respect; independence; ties to informal supports; community involvement; and desired employment. A "reasonable alternative" is one, which balances, without "significant negative impact", the enrollee's identified family care outcomes with reasonable cost and effort. A "negative impact" on identified family care outcomes includes, but is not limited to: disruption of ongoing relationships with family or friends; isolation from typical community settings and interactions; separation from the person's home community; lack of access to employment; lack of access to services, treatment, or learning opportunities necessary to increase or maintain the person's level of independence; provision of services in settings in which they are unlikely to be effective; and use of locked settings, and/or chemical or physical restraints. (A cost-effective alternative that has worked for persons who have needs and circumstances similar to the enrollee's without significant negative impact on their family care outcomes would likely be considered a "reasonable alternative." An alternative is not likely to be considered reasonable if it creates a risk of negative outcomes; if it is no less risky or costly than the alternative preferred by the enrollee; or, if any additional risk or cost is reasonable in relation to the enhanced ability to achieve the enrollee's identified family care outcomes.)

[12] At a minimum the following must be available from the CMO: access to person centered planning or opportunities for the member to direct the planning process with a focus on what he/she wants and needs, linking to other community services, self-directed care option, and coordination with acute and primary care providers.

Targeted Plan Review Types	Purpose in Family Care
	supports between the CMO and the member's acute and primary care providers ▪ verify that the member is living in his/her preferred living arrangement, unless the ISP demonstrates that the member's preferred living arrangement will jeopardize the member's health and safety, or the cost of providing services in the preferred arrangement as compared with other "reasonable alternatives" outweighs the benefits to the member in terms of preventing any negative impact on desired outcomes
3. Review of service plans of continuing Family Care enrollees	▪ verify that ISPs are reviewed when needed to respond to changes in the member's situation or within 180 days of the last ISP ▪ verify that Family Care services and support items are provided as quickly as necessary to preserve the health and safety of the CMO member ▪ if services are not provided as quickly as necessary, verify that the CMO made a good faith effort to secure services identified in the member's ISP ▪ verify that an individual's Family Care services and supports have not been improperly reduced (i.e., the reduction does not correspond with an alternative way of providing for the unchanged needs of the member or with the changed needs the member)
4. Review of Family Care enrollees living in an institution	▪ verify that any member who is living in a nursing home or other institutional setting, and who desires to return to the community, is reassessed on an ongoing basis by the CMO in order to actively plan for and seek to return the member to his/her chosen living situation, or a reasonable alternative
5. All reviews	▪ verify that the services requested by the member and identified in the member's ISP as necessary services do not exceed the member's identified needs ▪ verify that, if the CMO refuses to include a service in an ISP, these services are either outside the Family Care benefit package, outside the CMO's responsibility, exceed the member's identified needs, will result in outcomes that have negative consequences on the member's health and safety, that a 'reasonable alternative' can be provided ▪ verify that the services are not unnecessarily restrictive on the member (unless the care, treatment or support items have been ordered by a court)